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Can the Speed of Fertility Decline in sub-Saharan Africa be accelerated?

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**A “Road Map” to Accelerate the Fertility Decline in African
Countries That Are Less Advanced in Their Fertility Transition**

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Today, most developing countries have achieved much lower levels of mortality and fertility as well as much lower rates of population growth than they had experienced in the 1960s. The situation is quite different in Africa, and especially in sub-Saharan Africa (SSA). In many SSA countries, mortality declines stalled, or were even reversed in the 1980s and 1990s, because of the impact of the HIV/AIDS epidemic, the deterioration of the health systems, and the impact of civil wars and social unrest. The fertility decline that has generally been associated with the mortality decline (this is called the demographic transition), has also occurred much later in most African countries than elsewhere in the world (Guengant and May 2011a). Currently, about 80% of the SSA population lives in countries which are less advanced in their fertility transition. As a result, most African countries still have high rates of population growth and very young populations.

Most SSA countries will need to accommodate the doubling or even the tripling of their working age population by 2050. This unprecedented increase of the labor force, the *first challenge* that these countries must address, is an inescapable reality which will have to be dealt with. This phenomenon can be called the demographic “heritage of the past”, since it is the direct result of high fertility levels since the 1960s—a consequence of the lack of interest and the neglect of the demographic trends on the part of public authorities, the civil society, and international donors alike.

Indeed, providing jobs to all new job seekers in SSA will prove very difficult. A recent report of the African Development Bank states that the formal (i.e., modern) sector in Africa will not be able to absorb all upcoming young workers (African Development Bank 2012). In all African countries but three, the age group 15-29 represents more than 40% of the adult population (above age 15), a phenomenon known as the “youth bulge”. The informal sector will remain the major source of job creation for the youth, as it has been the case in most SSA countries in the past 30 years. All youth development strategies will need to address these hard facts. If they do not, and should the young people revolt against their living conditions, this might translate into major social disruptions similar to those that have been observed recently in several Northern African countries during the “Arab Spring”.

At the same time, the SSA countries will have to prepare for the future of their upcoming young generations and address the rapid increase of their elderly people (above age 65), whose numbers will be multiplied by a factor of 3 to 5 by 2050. Therefore, the *second challenge* that most SSA countries will need to address is to create the adequate conditions for bringing a better future for the African young generations. Future socioeconomic development and prosperity will require a rapid decline in the currently high dependency ratios, as it has occurred in today’s emerging economies. This can be achieved only through a fertility transition that will bring a steady decline of the proportion of youth aged less than 15 or 20 years. Such a decline will allow reallocating parts of the resources devoted to the health and education of large numbers of children below age 15, to the secondary and tertiary education of young adults and to the creation of new jobs. In fact, the corresponding changes in the age structure fulfill one of the

conditions needed to benefit from a potential demographic dividend, when changes in age structures bring more favorable dependency ratios and expand the relative size of the labor force. However, such a scenario implies for the majority of SSA countries a much more rapid fertility decline than the one that has been observed so far. This fertility decline can only be achieved if contraceptive coverage increases markedly from present low levels to rates of about 60% or more of women in union by 2050.

However, the dual challenge that most African countries must address now, i.e., assuming the heritage of the past and preparing for the future, can be managed through the design and implementation of sound population, health, education, and economic policies. These policies are most necessary in the countries that are lagging behind in their fertility transition (as mentioned, 80% of the population of SSA lives in these countries). Moreover, these policies must be put in place as soon as possible for these countries to capture the benefits of a demographic dividend, trigger inclusive growth, and reduce poverty levels.

Background and Data

The SSA high fertility countries, which experience slow demographic and fertility transitions, are found primarily in Western and Middle (Central) Africa. Fertility levels are still very high in these sub-regions, estimated at 5.5 and 6.1 children per woman in Western and Middle Africa, respectively. Use of modern contraception remains very low, at about 10 percent on average, or even less in Middle Africa, and has not progressed much over the past 10 years (Population Reference Bureau 2013). Overall, teenage pregnancies are numerous and reproductive health outcomes poor. Unmet needs for family planning are high, estimated at 25 to 30 percent of women on average. Induced abortions often substitute for the lack of quality modern contraceptive services, and they carry high risks of maternal mortality. Nonetheless, declines in infant and child mortality and fertility levels have taken place in most of these countries. Mortality declines, which fuel rapid population growth, have resumed in the last 15 years and have been significant, but fertility levels have declined at a snail's pace leading to a slow "erosion" of high fertility levels. In some countries, fertility declines have even stalled as a result of low and stagnant contraceptive prevalence rates (CPRs). In short, with respect to their demographic and fertility transitions, most SSA countries belong to the "last frontier of the last frontier".

Given this context, the major challenge as well as the paramount population policy question today is quite obvious: can these countries accelerate their demographic and, particularly, fertility transition? Faster fertility transitions could usher a window of opportunity to capture the potential benefits of a demographic dividend. Moreover, faster fertility declines would also enhance the formation of human capital (e.g., education and health) and the productivity of the labor force, and would allow the increase of productive investments (May 2012: 50-52).

The acceleration of the fertility transition in these countries will require persistent efforts to be conducted at the country level, one country at the time. The overall goal will be to overcome the traditional ideas and prejudices regarding population and reproductive health (Pop/RH) issues in sub-Saharan Africa in general, and in Western and Middle Africa in particular. One will also need to pay special attention to the weak political economy and limited “policy space” vis-à-vis Pop/RH issues in these countries.

The demographic data used in this paper come from the Demographic and Health Surveys (DHS) and/or the Multiple Indicators Cluster Sample Surveys (MICS). The results of several new DHS have been released recently (e.g., the 2012 Niger DHS). The other demographic data, such as the population projections, come from the 2010 United Nations population projections (United Nations 2011) and/or from the projections prepared for the recent study by the French Development Agency (AFD) (Guengant 2012). Finally, another stream of data is provided by the various policies and strategies, in particular the national population policies, the poverty reduction strategies (Poverty Reduction Strategy Papers or PRSPs), the reproductive health products strategies, the family planning market segmentation studies (for instance, the one prepared for Niger), and several other strategies (e.g., women or youth strategies).

The technical backgrounds of the analyses that are presented in this paper are to be found in the comprehensive paper by Guengant and May (2013), which covers the entire continent of Africa, including Northern Africa.

Determinants of Fertility

Fertility outcomes are shaped by two sets of determinants. The intermediate determinants of fertility, which are essentially socio-economic in nature, influence fertility *indirectly*. The proximate determinants of fertility, which are mostly biological and behavioral, influence fertility *directly*.

This section of the paper relies on an analysis of the Bongaarts model of the proximate determinants of fertility, with a focus on the index of contraception, since fertility declines will not occur without major increases in the contraceptive prevalence rates or CPRs (Guengant and May 2002). As it was demonstrated also with respect to the assumptions of future population projections, the index of contraception is key (Guengant and May 2011b). However, the role of the other proximate determinants needs to be assessed as well, in particular the marriage index (exposition to union) and the infecundability index (duration of postpartum insusceptibility linked to both the length of breastfeeding and the postpartum abstinence).

In most sub-Saharan African countries, the *intermediate determinants* of fertility—levels of education, health status, employment in the formal sector, income levels, and urban residence—are not conducive to bringing rapid declines in fertility. Although in African countries, as in

other developing countries, fertility levels are generally lower among the most educated and urban women (Bongaarts 2010), this has had so far a limited impact on national fertility levels because still too few women of reproductive age benefit from secondary or higher education levels, and because urbanization rates remain generally low. Moreover, policy interventions on the intermediate determinants generally bear results with a time lag, and their impact on fertility varies from one country to the next depending on other variables, noticeably family norms, social networks, and cultural values. Therefore, specific policy objectives such as raising education levels of girls (especially for secondary and tertiary education), reducing maternal and child mortality levels, increasing female labor participation in the formal sector, and achieving a more inclusive economic growth for women should be considered as objectives *per se*, and not as policy interventions aimed at influencing fertility directly and/or rapidly.

The *proximate determinants* of fertility include marriage (unions), postpartum infecundability (or insusceptibility), abortion (induced), contraception (modern and traditional¹), and sterility (May 2012: 233-234). Some of these determinants are more amenable to policy interventions than others, especially when one seeks to obtain results in the short term. It is for this reason that access to contraception has long stood at the top of the list of population policy interventions in high fertility countries. However, as mentioned, one should not underestimate the importance of the other proximate determinants of fertility, namely the postpartum infecundability, which is essentially linked to the duration of breastfeeding (which is decreasing in most SSA countries), the increasing age at marriage (age of entry into union, which is generally increasing), as well as the recourse to induced abortion especially in countries where access to family services is limited despite a large pent-up demand. Nonetheless, one should keep in mind that the inhibiting effects on fertility of the first two factors often cancel each other. In other words, shorter periods of breastfeeding increase fertility, but higher age at marriage decreases it (Guengant and May 2002; Guengant and May 2011b).

It appears that high fertility levels observed today in most African countries are largely the result of persistent low contraceptive prevalence rates. Conversely, the lower levels of fertility observed in most emerging, developing and some of the 13 African countries that have completed or are about to complete their fertility transition, result from rapid increases in the use of contraceptive methods over the past 40 or 50 years, particularly of efficient modern methods—a process that has been called the “contraceptive revolution”.

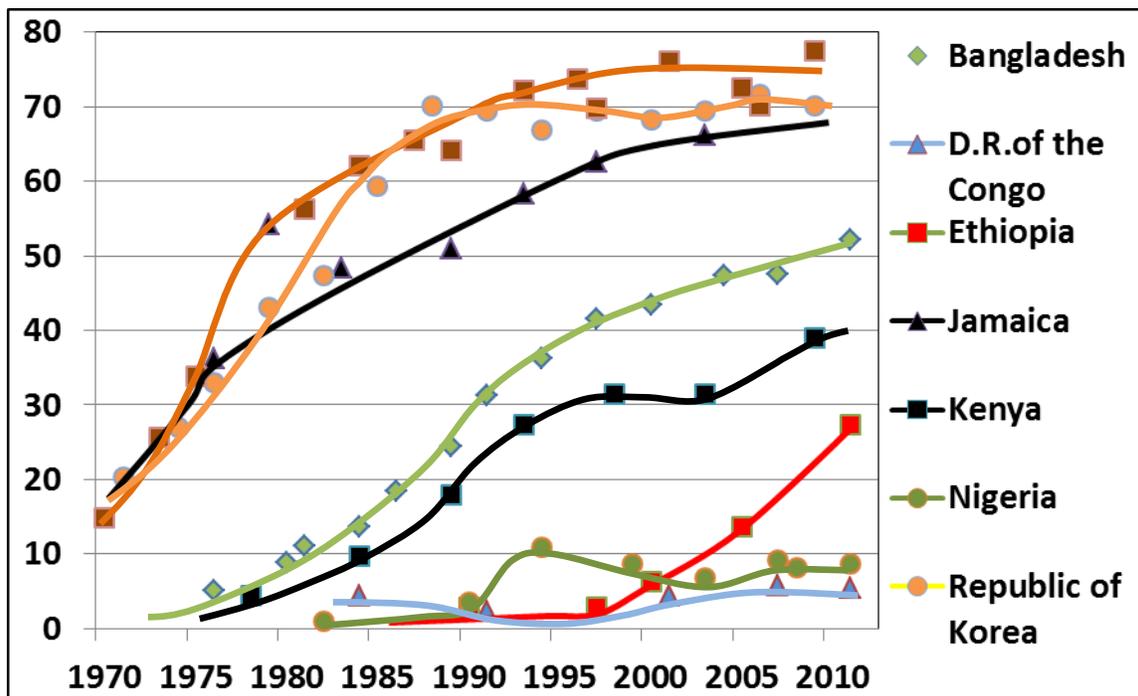
The low levels of contraceptive use, the rather weak demand for family planning, and the high percentage of unmet needs at the national level, as well as the inequalities between women with respect to these variables can be explained by pervasive family norms favouring large families (Romaniuk 2011: 21-22). Indeed, desired fertility in SSA (i.e., the ideal number of children) remains very high even among young women, and in many countries even among young women

¹ Modern contraceptive methods are hormonal (e.g., pill, implants, and injectable), chemical or mechanical (spermicides, IUDs, and barrier methods such as condoms), or surgical (male and female sterilization).

with secondary levels of education. In addition, one should not dismiss the importance of marriage at young ages and sometimes “child-marriages” as another explanatory factor for the high fertility levels observed in SSA. To a large extent, all this can be construed as a double denial of women’s rights: the denial of access to methods and the denial of information on contraception, which translates into the lack of reproductive choices.

This situation is largely the consequence of the lukewarm commitment or lack of engagement vis-à-vis family planning and reproductive health on the part of governments, the civil society, and donors alike. So far only two governments in sub-Saharan Africa, i.e., Rwanda and Ethiopia, appear to have organized successfully large-scale programs and/or campaigns in favor of family planning, like those organized in several Northern African and Asian countries. For instance, among eight countries surveyed in Western Africa, only half had a government budget-line item for the procurement of contraceptives (USAID Deliver Project 2011).

Figure 1: Progress in the use of modern contraceptive methods (in percentage) in various emerging and sub-Saharan countries since 1970



Source: United Nations 2012, “2012 Update for the MDG Database” Contraceptive Prevalence; see <http://www.un.org/esa/population/unpop.htm> and United Nations Data base.

Persistent high fertility levels in most African countries cause numerous high-risk pregnancies (at least one pregnancy out of two, in most cases), which are associated with the four “toos”: pregnancies that are too early, too often, too close, and too late. This translates into very high maternal mortality ratios, high under-five mortality rates, and high proportions of stunted children among the children who do survive. Moreover, the future of these children is

compromised because they are less resistant to diseases and have more difficulties to learn at school (World Bank 2010: 14). These poor and undesirable outcomes affect the poorest households and jeopardize the chances of most countries to fulfill their development objectives and achieve a more inclusive growth.

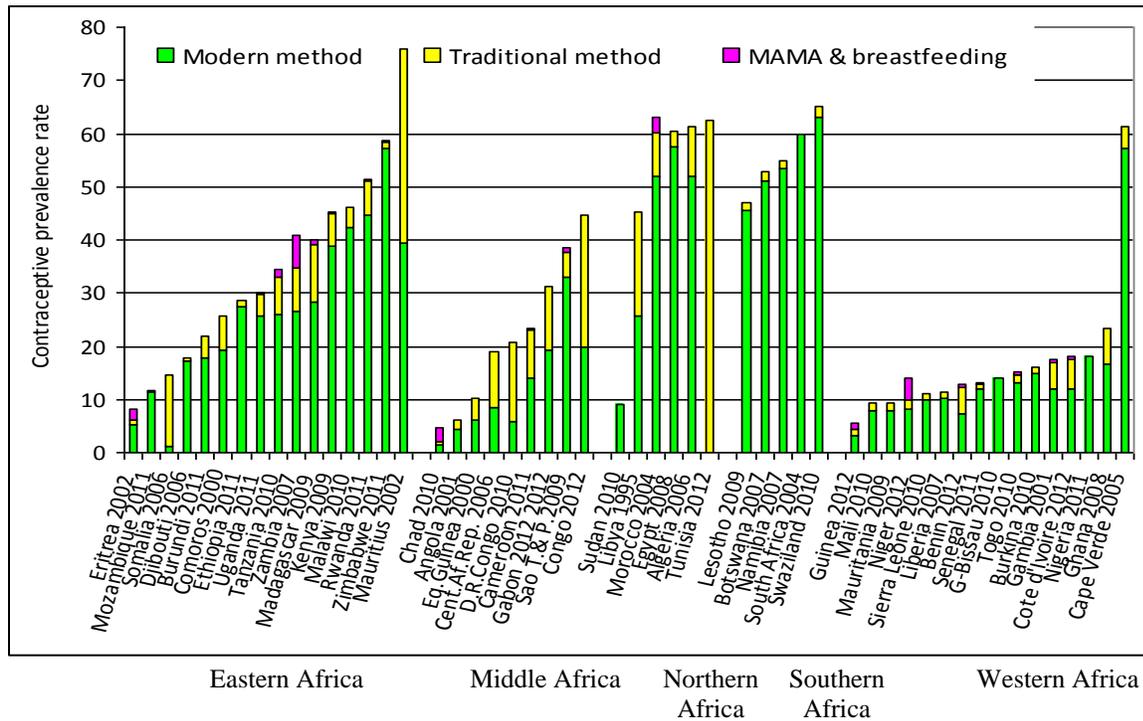
Figure 1 illustrates the striking gap with respect to the increase in the use of modern contraception since 1970 between emerging market countries, on the one hand, and most SSA countries on the other. As can be seen, most countries considered here had modern contraceptive prevalence rates of 20% at most around 1970. In the following 30 to 40 years, modern contraceptive rates have increased rapidly to reach at least 50% and in several cases 60% or more in various North African and Asian countries. On the contrary, contraceptive prevalence rates have not reached 20% in a majority of sub-Saharan African countries, although there are a few recent exceptions to this general pattern (e.g., Ethiopia and Rwanda, and to some extent Madagascar). Obviously, the contraceptive revolution has not yet touched most SSA countries.

Figure 2² presents the most recent contraceptive prevalence rates (CPRs) for 52 out of the 53 African countries, for modern and traditional contraceptive methods (there are no data for the Seychelles). These data are fairly recent since they were collected between 2000 and 2012, except for Libya. It should be noted that in some countries modern contraceptive coverage is just a small fraction of traditional contraceptive use. This is the case in particular in Middle African countries.

Only 7 countries, accounting for 13% of the continent's population, had a recent contraceptive rate above 60%. These countries are located in Northern and Southern Africa and/or are island-countries, i.e., Morocco, Egypt, Cape Verde, Algeria, Tunisia, Swaziland, Mauritius, and Seychelles. In Ghana, low levels of contraceptive use and relatively low levels of fertility might be explained by the higher incidence of induced abortion in that country. At the other end of the spectrum, 30 countries in Africa (including Northern Africa) accounting for 62% of the total population of the continent have a contraceptive rate below 30%, which is less than half the minimum prevalence rate required to achieve the contraceptive revolution and complete the fertility transition. It is worth noting that all Western African countries but two (Cape Verde and Ghana) have contraceptive rates below 20%. To turn to sub-Saharan Africa, 78% of the population lives in a country where less than 30% of the women in union use a contraceptive method (this population percentage is probably skewed because of the huge demographic weight of Nigeria, where contraceptive use is very low).

² For some countries in Figure 2, contraceptive prevalence rates include the "LAM" (Lactational Amenorrhea Method), which is now often regarded as a modern method of contraception, as well as breastfeeding, which is generally considered a traditional method. However, it should be noted that the effectiveness of LAM or "postpartum contraception" is based on three conditions that must be met simultaneously: 1) the baby must be less than six months old, 2) the mother must be amenorrheic (not having her periods back), and 3) breastfeeding should be practiced day and night, on demand. LAM is often equated with breastfeeding, and the percentages of LAM users are generally low and unreliable. For comparison purposes, therefore, the percentages of "users" of LAM or breastfeeding have been displayed separately from the percentages of "users" of other methods.

Figure 2: Most recent contraceptive prevalence rates (in percentage) for African countries by type of method, region and decreasing order of total prevalence



Sources: United Nations 2012, “Update for the MDG Database” Contraceptive prevalence, and DHS and MICS 4 surveys results (final or preliminary results).

Rapid increases of contraceptive coverage will be challenging in these high fertility countries. However, Ethiopia appears to have been able to increase its contraceptive coverage at a rather rapid pace (World Bank 2007; Teller and Hailemariam 2011). Indeed, these countries will need to increase their CPRs from 10% or 20% to 60% or more in less than 40 years in order to achieve their fertility transition by 2050. This is illustrated in a study from the Berlin Institute, which shows that SSA countries will need CPRs ranging between 50% and 65% by 2050 to reach fertility levels comprised between three and two children per woman (Sippel et al. 2011: 58).

In most SSA countries, the total demand for family planning remains rather weak and, paradoxically, only a small portion of this demand is satisfied, which is reflected by the high levels of unmet needs³ estimated on average to be at about 25% to 30% (Guengant and Rafalimanana 2005). Relatively recent DHS results for 39 countries confirm this finding, yielding an unweight average of 25% of unmet need—a figure close to the average current use of

³ Unmet needs for family planning refer to the condition of wanting to avoid or to postpone childbearing, but not using any method of contraception, and the total demand for family planning refers to the sum of married women using a method of contraception plus those in need but not using any method. This is a demand-measure constructed from survey data, which attempts to estimate the percentage of women who want to delay their next pregnancy by two years but do not currently use a contraceptive method. However, the percentage of unmet needs may increase as contraceptives become more readily available.

any method, i.e., 29%. This yields a total demand of 54%, but with considerable variations between countries: from 23% in Chad to less than 60% in a majority of countries (24 out of 39) and to 60% to 82% in 15 countries. However, according to the same surveys, only half (49%) of these needs are satisfied if all methods used are considered, and only a third (37%) if one considers only the use of modern and efficient contraceptive methods.

Policy Steps to Accelerate the Fertility Transition

After the focus on the proximate determinants of fertility and, particularly, on contraceptive use, the second section of the paper examines the various strategies and policy analyses that could be designed to address the issues of high levels of fertility and low contraceptive prevalence rates (CPRs) in sub-Saharan Africa. Policies to decrease fertility and increase contraceptive coverage in SSA will require a blend of bold, strategic, and coherent interventions, which will need to be implemented and followed up carefully and consistently over a rather long period of time.

In order to decrease high levels of fertility and increase CPRs in SSA countries, seven broad areas of interventions have been identified, as follows: (a) crafting a new discourse on population and reproductive health (Pop/RH) issues; (b) filling data collection and research gaps; (c) unifying population data throughout all development strategies; (d) enhancing policy dialogue efforts at the highest levels of leadership; (e) expanding family planning coverage; (f) coordinating more efficiently ongoing Pop/RH activities; and (g) identifying a new cadre of African Pop/RH champions.

The *new discourse on Pop/RH issues* in sub-Saharan Africa should emphasize the possibility for several Western and Middle African countries to attain middle income status within a reasonable period of time. Provided they accelerate their fertility transition, these countries could then become emerging economies as stated in their poverty reduction strategies' goals. This new discourse should look beyond population numbers and the rapid pace of demographic growth, and focus rather on age structures and their transformations through non coercive and voluntary fertility decline. As such, the new discourse should highlight dependency ratios, the youth bulge, as well as the potential benefits of the demographic dividend. Women's health and gender equality issues should also be highlighted and geographic economy considerations could be addressed as well (e.g., urbanization and population densification). In short, this new discourse should bring macro-demographic issues within the broader framework of socioeconomic development and accelerated economic growth.

Data collection and research gaps will need to be addressed as well, in order to provide the information that will enable policymakers to craft the new Pop/RH discourse. First of all, countries will need a Master Plan to collect the needed demographic data (e.g., censuses, surveys, and civil registration), as well as analyze and use them on a regular basis. Next, countries will need to summarize this information and make it usable by policy leaders. Today,

only half of Western and Middle African countries have population monographs, on the model of those prepared under the aegis of AFD (Guengant 2012)⁴. It is suggested to prepare monographs for countries that do not have one yet, particularly in Middle Africa and Madagascar (one is being prepared for the Democratic Republic of Congo), and to update existing Western African monographs at two- or three-year intervals. These new monographs should be prepared with the help of national consultants, and national experts should be trained to update existing monographs. In addition, many Western and Middle African countries do not prepare population projections on a regular basis, whereas every country should have a set of national population projections updated regularly. Moreover, national population policies need to be redesigned, and complemented with meaningful sets of indicators. So far, only Niger has an “implementable” national population policy document, which was adopted in 2007. Finally, family planning market segmentation studies are still rare in the region (again, the exception is Niger), and RH products security strategies should be either updated and/or prepared.

The new information that will be collected and generated will enable policy makers at the national level to *unify Pop/RH data* throughout all development and strategic documents. Too often, poverty reduction strategies use population estimates and projections results that are different from those to be found in national population projections and policies, and other government strategic documents. Many strategies (e.g., on gender, youth, women, etc.), rely on various data, which may be out of date, contradictory, and/or do not use data numbers but only percentages (i.e., without a solid grasp of denominators, which are key in demographic and social statistics). It is suggested to prepare common Pop/RH data matrices that would feed into all development strategies at the national level. As mentioned, it is proposed to work upstream to satisfy the requirements for Pop/RH data, through the preparation of Pop/RH data collection strategies (e.g., a Master Plan) at the country level.

Simple, pedagogic tools will be necessary to share the new discourse on Pop/RH issues, enhance the *policy dialogue with the highest level of leadership*, and overcome the genuine “demographic illiteracy” of many leaders. There is still some confusion, even among development professionals, about the concept of the “new demography”, the one that deals with age structures and the demographic dividend, which is based on the findings of the East Asian economic “miracle”. Many leaders still see large populations as positive outcomes, whereas it is the age structures and their transformation through rapid fertility decline that are the main engine of potential demographic dividends and that can foster economic growth provided sound economic policies are adopted as well. Moreover, it should be stressed that the benefits of the demographic dividend are not automatic, but need to be nurtured and captured with the right mix of social and

⁴ The countries covered under the AFD study coordinated by Jean-Pierre Guengant and *Initiatives Conseil International* (ICI) are all located in Western Africa, namely Benin, Burkina Faso, Côte d’Ivoire, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal, and Togo. Chad, in Middle Africa, has been added to this series and a monograph on DR Congo is under preparation.

economic policies (Gribble and Bremner 2012). In addition, it should be kept in mind that sub-Saharan countries may not benefit from the demographic dividend to the same extent East Asian countries did (Eastwood and Lipton 2011).

The *expansion of family planning coverage* is absolutely necessary to accelerate the fertility transition. As a first step, it is proposed to boost supply-side efforts in order to satisfy the unmet needs for family planning within a time frame of 15 to 20 years. This will require an increase of the contraceptive prevalence rates (CPR) at the rate of 1.5 percentage points per year. In parallel, one needs to boost the demand for smaller families and enhance women's choices, as it was done elsewhere in the world. This two-track process would make it possible to reach CPRs of about 40 percent within 15 to 20 years. This supply-side effort will necessitate the strengthening of contraceptive security, funding of commodities, and supply-chain and programmatic logistics. The demand-side effort will require massive and repetitive communication campaigns. In this respect, a good model to replicate elsewhere would be to out-source nation-wide campaigns of information, education and communication (IEC) and behavior change communication (BCC) to recognized leaders in advocacy activities (e.g., *Animas Sutura* in Niger). Overall, one will also need a family planning policy and programmatic shift from birth spacing to birth limiting.

A *better coordination of ongoing Pop/RH activities* at the country level is also necessary. This can be addressed through the preparation of country maps detailing interventions by governments, development partners, and NGOs in the area of Pop/RH. Such maps would enable policy makers to identify potential gaps in Pop/RH activities and entice governments and/or donors to fill such gaps. Moreover, these maps should be forward-looking in order to anticipate future funding and human resources requirements, since Pop/RH activities should expand considerably over the next decades, especially in Western and Middle Africa.

A final hurdle in triggering rapid fertility declines in SSA is the *lack of sub-Saharan Pop/RH champions*. The region needs a cadre of charismatic leaders that should be genuinely convinced themselves, before they can possibly convince others. Therefore, there is a real need to first identify and then nurture a new cohort of African Pop/RH champions and let flourish the potential African *Mechai Viravaidyas* (the famous activist from Thailand). This scouting effort should be directed at civil society and NGOs, first through the identification of suitable candidates and thereafter through their *ad hoc* mentoring. This endeavor should be bottom-up, and aimed also at motivating health personnel (a good blueprint is the *Guide en santé de la reproduction* of Chad) and at identifying potential social and community leaders. It should also be envisaged to organize study tours of African Pop/RH leaders and champions to countries that have succeeded in reducing their high fertility levels (e.g., Tunisia, Iran, Indonesia, etc.). All these suggested actions should help identify Pop/RH champions and build the capacity of the needed leadership on Pop/RH issues in SSA.

With respect to the operational implementation of these activities, it is suggested to adopt a two-prong strategy, as follows:

- First, the bulk of these activities should focus on Middle Africa, where there is a need to prepare country-specific Pop/RH monographs, with the view of bringing these countries – in terms of data collection and analysis and Pop/RH tools – to the same level that was attained by Western African countries under the work sponsored by the French Development Agency (AFD), with the support of USAID and the French Government, as well as the Bill & Melinda Gates and the William and Flora Hewlett foundations; and
- Second, the proposed activities will help follow up, monitor, internalize, and institutionalize the Pop/RH work that was already done in Western Africa. In particular, one will need to evaluate the outcomes of the Ouagadougou Conference “Population, Development, and Family Planning in Francophone West Africa: The Urgency for Action”, which was held in February 8-11, 2011.

Discussion and Conclusion

To trigger a fertility transition in SSA high fertility countries, it is assumed that four key elements would be required, as follows: (a) a steady increase in the contraceptive coverage for modern methods; (b) a set of policy analyses as well as policy documents and strategies to help implement stronger family planning programs; (c) a much stronger commitment on the part of the political leadership; and, last but not least, (d) a higher demand for lower fertility. As this paper has focused mostly on the first three of these elements, it has to some extent left aside the demand-side dimension of the fertility equation, which in our view would warrant a detailed analysis. Demand-creation is a complex issue that has to do with social norms, the status of women, etc., but we assume that the fulfillment of the three first supply-side conditions will also help to change eventually the demand for large families. However, the improvement of the demand for lower fertility levels would necessitate also an array of policies that go beyond the realm of family planning interventions *per se*.

The “road map” that has been presented in this paper identifies chiefly a set of supply-side policies and programs that could help accelerate the fertility transition in SSA high fertility countries. Among the major steps presented in the “road map”, one should highlight the preparation of sound population projections, the formulation of a national population policy (or shorter policy declarations, like the one issued in Niger), the preparation of a poverty reduction strategy (which needs to be informed by more rigorous demographic analysis), and a family planning market segmentation study. These strategic and policy documents must be complemented by other policy interventions, such as the procurement of contraceptives (including the improvement of the supply chain), the launching of massive and repetitive sensitization campaigns and, last but not least, the strengthening of the overall political commitment (May 2012).

However, in order to improve the supply-side dimensions of the fertility equation, this paper submits that it will be necessary, but not sufficient, to focus future efforts on three major areas, but also to *reorder* the list of priorities. As proposed now, these prioritized major areas would become: (a) to create a much stronger commitment of the part of the political leadership with respect to population, family planning, and reproductive health; (b) to improve policies and strategies surrounding the provision of family planning services; and (c) to improve the provision of the family planning services themselves.

First and foremost, it is deemed crucial to achieve a much stronger commitment on the part of the political leadership. In a nutshell, African leaders need to truly *lead* their populations into the demographic and fertility transitions, which only very few have done so far. Unless Africa leaders do so, one will see only a very slow “erosion” of high fertility levels, as we observe currently, but not decisive and brisk fertility declines that are necessary to trigger fast transformations of the age structure—one of the prerequisites to capture the benefits of a demographic dividend. African leaders will also need to shift their discourse from birth spacing to birth limiting, and to understand the far-reaching implications of demographic patterns and trends (Donaldson 2011).

The second and third priorities, which are to achieve a better coordination of ongoing Pop/RH activities at the country level and to expand the family planning coverage, respectively, do not need to be elaborated upon any further since they have been extensively dealt with in this paper.

To conclude, it is important to stress that the time to act is now, not tomorrow. If SSA high fertility countries want to address the “heritage of the past” and prepare for the future, and if they want to capture the potential benefits of a demographic dividend, they will need to act rapidly and decisively. This will be the only way for the SSA countries and their leaders to bring their demographic outcomes in line with their economic aspirations.

References

- African Development Bank (2012). *African Economic Outlook 2012. Special Theme: Promoting Youth Employment*. Tunis: African Development Bank (AfDB).
- Bongaarts, J. (2010). *The Causes of Education Differences in Fertility in sub-Saharan Africa*. Working Paper No. 20, New York: The Population Council.
- Donaldson, P.J. (2011). *Toward an Engaged Public Demography* (Occasional Paper). Washington, DC: Population Reference Bureau.
- Eastwood, R. and Lipton, M. (2011). “Demographic transition in sub-Saharan Africa: How big will the economic dividend be?”. *Population Studies* 65(1): 9-35.
- Gribble, J.N. and Bremner, J. (2012). “Achieving a Demographic Dividend”. *Population Bulletin* 67(2).
- Guengant, J.P. (2012). *How Can We Capitalize on the Demographic Dividend? Demographics at the Heart of Development Pathways: Synthesis of studies conducted in WAEMU countries and in Ghana, Guinea, Mauritania and Nigeria*. Paris: French Development Agency (AFD) & Institute for Research in Development (IRD).
- Guengant, J.P. and May, J.F. (2002). Impact of the Proximate Determinants on the Future Course of Fertility in sub-Saharan Africa [Special issue 2002]. *Population Bulletin of the United Nations* 46/47, 71–95.
- Guengant, J.P. and May, J.F. (2011a). “L’Afrique subsaharienne dans la démographie mondiale”. In *ÉTVDES No. 4154*, October, 305-316.
- Guengant, J.P. and May, J.F. (2011b). *Proximate Determinants of Fertility in sub-Saharan Africa and Their Possible Use in Fertility Projection*, Paper presented at the United Nations Expert Group Meeting on Recent and Future Trends in Fertility. New York, 2-4 December, 2009 (Population Division Expert Paper No. 2011/13), New York: United Nations, Department of Economic and Social Affairs.
- Guengant, J.P. and May, J.F. (2013). *Africa 2050: African Demography*. Washington, DC: Centennial Group for Emerging Market Forum, 2013.
- Guengant, J.P. and Rafalimanana, H. (2005). *The Cairo Approach: Making RH and FP Programmes More Acceptable or Embracing Too Much?* Paper presented at the XXV International Population Conference of IUSSP, Tours, France, July 18-23, 2005; see <http://iussp2005.princeton.edu/download.aspx?submissionId=50775>.

May, J.F. (2012). *World Population Policies: Their Origin, Evolution, and Impact*, New York: Springer.

Population Reference Bureau (2013). *2013 World Population Data Sheet*. Washington, DC: Population Reference Bureau; see www.prb.org.

Romaniuk, A. (2011). "Persistence of High Fertility in Tropical Africa: The Case of the Democratic Republic of the Congo". *Population and Development Review* 37(1): 1-28.

Sippel, L., Kiziak, T., Woellert, F. and Klingholz, R. (2011). *Africa's Demographic Challenges: How a Young Population can make Development Possible*. Berlin: Berlin Institute for Population and Development, in cooperation with Deutsche Stiftung Weltbevölkerung (DSW).

Teller, C. and Hailemariam, A. (Eds.). (2011). *The Demographic Transition and Development in Africa: The Unique Case of Ethiopia*. New York: Springer.

United Nations. (2011). *World Population Prospects: The 2010 Revision*. New York: United Nations, Department of Economic and Social Affairs, Population Division; see <http://www.un.org/esa/population>.

United Nations.(2012). *2012 Update for the MDG Database. Contraceptive Prevalence*. New York: United Nations, Department of Economic and Social Affairs, Population Division; see <http://www.un.org/esa/population/unpop.htm>.

USAID Deliver Project. (2011). *Contraceptive Security Indicators Data*. Arlington: USAID Deliver Project, Task Order 1.

World Bank. (2007). *Capturing the Demographic Bonus in Ethiopia: Gender, Development, and Demographic Actions*. Washington, DC: The World Bank.

World Bank. (2010). *African Development Indicators 2010*. Washington, DC: The World Bank; see www.worldbank.org/adi.